

KENTUCKY BOARD OF LICENSURE FOR OCCUPATIONAL THERAPY

GUIDELINES FOR DPAM SPECIALTY CERTIFICATION APPLICATION PROCESS

It shall be unlawful for a person licensed under this chapter to utilize occupational therapy interventions involving deep physical agent modalities, unless requirements have been met

In accordance with The Occupational Therapy Practice Act, KRS 319A .080 (4), and the Administrative Regulations, 201 KAR 28:170, which provide procedures for putting The Act into practice, all of the following documents shall be submitted to KBLOT prior to being approved for DPAM Specialty Certification.

- A. Completed ***DPAM Specialty Certification Application Form*** with the \$25.00 application fee in the form of a **check or money order** made out to the **Kentucky State Treasurer**.
- B. Completed ***DPAM Training and Instruction Form*** for your specific level of licensure or DPAM requirements
 - a. occupational therapist, OT/L
 - b. occupational therapy assistant or, OTA/L
 - c. occupational therapist also certified as a certified hand therapist.
- C. Completed ***DPAM Educational Requirements Course, Workshop, Seminar Description Form(s)*** for **each** training and instruction session attended.
- D. Completed ***DPAM Supervised Treatment Sessions Form***.
 - a. The supervisor(s) signing off on the specific treatment sessions shall meet the requirements to be a DPAM Supervisor prior to the supervised treatment session(s) taking place.
 - b. For information about the DPAM Supervisor Application Process, please refer to these separate guidelines. ***Guidelines for DPAM Supervisor Application Process***.

Mail To:
Kentucky Board of Licensure for Occupational Therapy
P.O. Box 1360
Frankfort, KY 40602

KENTUCKY BOARD OF LICENSURE FOR OCCUPATIONAL THERAPY
GUIDELINES FOR
DEEP PHYSICAL AGENT MODALITIES (DPAM)
TRAINING & INSTRUCTION FORM

The training and instruction shall be earned by direct personal participation in courses, workshops, or seminars. The course content shall include specific areas pertaining to the application and use of deep physical agent modalities.

In accordance with The Occupational Therapy Practice Act, KRS 319A .080 (4), and the Administrative Regulations, 201 KAR 28:170, which provide procedures for putting the Act into practice, specific training and instruction shall be demonstrated prior to being approved as DPAM Specialty Certified. For completing the ***DPAM Training and Instruction Form***, you shall determine your level of licensure or DPAM requirements as specified in KRS 319 A. 080. (4).

- c. occupational therapist shall demonstrate thirty-six (36) hours of training
- d. occupational therapy assistant shall demonstrate seventy-two (72) hours of training
- e. occupational therapist, also certified as a certified hand therapist shall demonstrate twelve (12) hours of training

On the ***DPAM Training and Instruction Form***, the topics for each course, workshop or seminar shall determine the specific content areas covered and the specific time spent in hands on, laboratory activities. The letters a – j correspond to the following content areas:

- a) Principles of physics related to specific properties of light, water, temperature, sound, and electricity;
- (b) Physiological, neurophysiological, and electrophysiological changes which occur as a result of the application of each of the agents identified in KRS 319A.010(8);
- (c) Theory and principles of the utilization of deep physical agents which includes guidelines for treatment or administration of agents within the philosophical framework of occupational therapy;
- (d) The rational and application of the use of deep physical agents;
- (e) The physical concepts of ion movement;
- (f) Critical thinking and decision making regarding the indications and contraindications in the use of deep physical agents;
- (g) Types selection and placement of various agents utilized;
- (h) Methods of documenting the effectiveness of immediate and long-term effects of interventions;
- (i) Characteristics of equipment including safe operation, adjustment, and care of the equipment; and
- (b) Application and storage of specific pharmacological agents.

\$25.00 Fee Received_____

- Email address: _____

4.	Daytime Phone	#	Other Phone #:
5.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	I have enclosed the required \$25.00 DPAM Specialty Certification Application fee in the form of check or money order payable to the Kentucky State Treasurer.
6.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	I certify that I have successfully completed the required hours of instruction earned through direct personal participation in courses, workshops, or seminars that includes hands-on use of Iontophoresis, Ultrasound, and Electrical Stimulation.
7.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	I certify that the courses, workshops, or seminars successfully covered each required topic area listed in 201 KAR 28:170 Section 3 (2) (a) – (j) and any hours not concerning these topics are excluded .
8.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	I have completed and attached the correct <i>DPAM Specialty Certification Training and Instruction Form</i> for my level of licensure and training requirement as specified by KRS 319A.080 Section 4.
9.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	I have correctly calculated only the actual hours of courses, workshops or seminar content which specifically address 201 KAR 28:170 Section 3 (2) (a) – (j), subtracting breaks, meals, and business meetings.
10.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	I have attached a completed <i>DPAM Specialty Certification Supervision Verification Form</i> .
11.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	I have enclosed a completed Supervised Treatment Sessions Form.

I, the **applicant** named in the above, do hereby certify under penalty of law that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I understand that the Board has the right to request additional information regarding any course that has not specifically been reviewed by the Board to determine the amount of credit that will be given for that specific course or courses. I am aware that, should investigation at any time disclose any such misrepresentation or falsification, my Deep Physical Agent Modalities Specialty Certification application could be rejected or my license revoked by the Kentucky Board of Licensure for Occupational Therapy.

*An Occupational Therapist hold a CHT shall enclose verification of current credentials from the American Society of Hand Therapists.

OCCUPATIONAL THERAPIST TRAINING & INSTRUCTION FORM

2. License Number : _____

Date(s) of Courses	Course Title	Total Hours	Lab time	Check Topics Included									
				a	b	c	d	e	f	g	h	i	j
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Hours Completed (Minimum of 36 hours required)				Each column above shall contain at least one check.									

I, the **applicant** named in the above, do hereby certify under penalty of law that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should investigation at any time disclose any such misrepresentation or falsification, my Deep Physical Agent Modalities Specialty Certification application could be rejected or my license revoked by the Kentucky Board of Licensure for Occupational Therapy.

Date _____

KENTUCKY BOARD OF LICENSURE FOR OCCUPATIONAL THERAPY DPAM SPECIALTY CERTIFICATION

OCCUPATIONAL THERAPY ASSISTANT TRAINING & INSTRUCTION FORM

1. Licensee Name: _____
Last
First
Middle
Maiden

2. License Number: _____

Please list all courses, workshops and seminars participated in for completion of requirements as listed in 201 KAR 28:170 Section 3. The 72 hours of training and instruction shall document direct personal participation time including use of equipment to perform iontophoresis, ultrasound, and electrical stimulation. This does not include time in courses, workshops, or seminars that covered topics other than (2) (a) through (j), time considered as breaks, meals, or business meetings.

Date(s) of Courses	Course Title	Total Hours	Lab Time	Check Topics Included									
				a	b	c	d	e	f	g	h	i	j
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Hours Completed (Minimum of 72 hours required)				Each column above shall contain at least one check.									

APPLICANT'S AFFIDAVIT

I, the applicant named in the above, do hereby certify under penalty of law that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should investigation at any time disclose any such misrepresentation or falsification, my Deep Physical Agent Modalities Specialty Certification application could be rejected or my license revoked by the Kentucky Board of Licensure for Occupational Therapy.

 Signature of Deep Physical Agent Specialty Certification Applicant

 Date

3. Program Title: _____
4. Date(s) of Program: _____
(Course approval is good for a twelve (12) month period.)
5. Program Presenter: _____
6. Organization Sponsoring the Course: _____
7. Location of Program: _____
8. Start Time: _____ End Time: _____ Break Times: _____
9. Total Contact Hours: _____ Hours Spent in Hands On Laboratory Time: _____
10. Was the program pre-approved by the Board? ☐ Yes ☐ No
11. Please attach a copy of the course -agenda of the workshop or seminar which includes a summary of learning objectives and teaching methods employed in the workshop or seminar including detailed time for each topic and which course objectives (a – j) was addressed.
☐ Didactic ☐ Lab hands on ☐ On-line
12. Provider shall give each participant an official verification of attendance signed by the designated program official confirming the participant’s successful training or course completion.

KENTUCKY BOARD OF LICENSURE FOR OCCUPATIONAL THERAPY
DPAM SPECIALTY CERTIFICATION
SUPERVISED TREATMENT SESSIONS FORM

D

The information in the table below SHALL be completed by the KBLOT approved DPAM supervisor providing direct supervision for the treatment session. Each session shall be signed and dated on the date the treatment occurred.

DPAM Applicant's Name: _____

DPAM Supervisor Print Name:

DPAM Supervisor License number:

“DPAM Specialty Certification” means the certification issued to a **Kentucky-licensed occupational therapist or licensed occupational therapist assistant who meets the standards set forth in KRS 319A.080 and this administrative regulation and who has been certified by the board.**

- a) Principles of physics related to specific properties of light, water, temperature, sound and electricity
- b) Physiological, neurophysiological, and electrophysiological changes which occur as a result of the application of each of the agents identified in KRS 319A.010 (8)
- c) Theory and principles of the utilization of deep physical agents which includes guidelines for treatment or administration of agents within the philosophical framework of occupational therapy
- d) The rational and application of the use of deep physical agents
- e) The physical concepts of ion movement
- f) Critical thinking and decision making regarding the indications and contraindications in the use of deep physical agents

Specific DPAM Utilized	Demonstration of knowledge skill and competence in the areas of						Signature of DPAM Supervisor Approved by the Board and Date
	a	b	c	d	e	f	
Iontophoresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Electrical Stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

The supervised treatment sessions shall include at least one session of iontophoresis, ultrasound and electrical stimulation. The remaining two sessions may cover any DPAM identified in KRS 319 A.010 (8).

DPAM SPECIALTY CERTIFICATION SUPERVISOR'S AFFIDAVIT (each supervisor shall sign)

I, the supervisor, do hereby certify under penalty of law that I personally understand 201 KAR 28:170, Section 4, (1) through (5) and have determined that items (a) through (f) have been addressed during the supervised treatment sessions and that the applicant for DPAM Specialty Certification has sufficiently answered all individual items and that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should investigation at any time disclose any such misrepresentation or falsification, my Deep Physical Agent Modalities Supervisor Certification could be revoked or actions may be taken to have my license revoked by the Kentucky Board of Occupational Therapy.

Signature of Deep Physical Treatment Session Supervisor

Date